

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445017	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  06/06/2017
NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT MARYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  A life safety survey was conducted by the state of Tennessee Department of Health, Division of health licensure and regulation office of health care facilities on 6/5 & 6/6/17. During this life safety survey, Asbury Place Maryville was not found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life safety from fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition.  The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K 222- Egress Doors		
K 222 SS=D	NFPA 101 Egress Doors  Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are	K 222	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>It is the facilities practice to ensure that we maintain delayed egress doors having the required signage for 2 of 21 smoke compartments. The facility ordered the appropriate egress signage for exit by room 102 and the first floor living room on 6/6/2017. The signs will be installed by 6/30/17.</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All other Delayed egress doors were checked by the facilities director on 6/6/2017 to insure proper egress signage. 100% compliance was noted for other doors. The doors needing delayed egress signage were installed on 6/9/2017</p> <p>3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.</p>		7/22/17 CWN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 222	Continued From page 1 being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 <b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b> Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 <b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b> Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 <b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b> Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain delayed egress doors. This	K 222	The Facilities Director will educate all maintenance staff regarding regulations for egress doors and how to inspect them by June 30, 2017.  4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.  All signage will be checked monthly on an ongoing basis as part of our routine inspection schedule, by the facility director or maintenance assistant. The results of the monthly checks will be reported to QAPI committee x 3 months.		
		K 281	K 281 Illumination of Means of Egress  1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  It is the facilities practice to ensure exit discharges is provided with illumination that affects 6 of 21 smoke compartments. A bid was received on 6/9/2017 to ensure exit discharge illumination will be provided at the two exit discharge stairwells on the west side of the facility. Installation of proper illumination on the exit doors on the west side of the facility will be installed on 6/30/2017.		7/22/17 CPN

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K 222	Continued From page 2 deficiency affected 2 of 21 smoke compartments.  NFPA 101, 19.2.2.2 NFPA 101, 7.2.1.6.1  The findings include:  Observation and interview with the maintenance director 6/5/17 at 8:10 PM revealed delayed egress doors by room 102 and first floor living room did not have the required signage.  The maintenance director was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 6/6/17.	<del>K 222</del> 281	2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.  100% compliance was noted for other 15 exit discharge doors. Installation of proper illumination on the exit doors on the west side of the facility will be installed on 6/30/2017.		
K 281 SS=E	NFPA 101 Illumination of Means of Egress  Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit discharges were provided with illumination. This deficiency affected 6 of 21 smoke compartments.  NFPA 101, 19.7.6, 19.2.8  The findings include:  Observation and interview with the maintenance director on 6/5/17 10:00 PM and 10:39 PM revealed the exit discharges from the two	K 281	3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.  The Facilities Director will educate all maintenance staff regarding regulations for exit discharge illumination and how to inspect them by June 30, 2017.  4. How the corrective action(s) will be monitored to ensure the  deficient practice will not recur; i.e. what quality assurance program will be put into place.  All exit discharge illumination will be checked monthly on an ongoing basis as part of our routine inspection schedule, by the facility director or maintenance assistant. The results of the monthly checks will be reported to QAPI monthly x: sheet Page 3 of 10 3 months.		

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K 281	Continued From page 3 stairwells on the west side of the facility did not have egress illumination.  The maintenance director was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 6/6/17.	K 281 324	K 324 Cooking Facilities  1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?		7/22/17 CPN
K 324 SS=E	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide required fire extinguishers. This	K 324	It is the facilities practice to provide required fire extinguishers that open to the corridor using cooking facilities that affect 3 of 21 smoke compartments. The facility ordered 3 fire extinguishers on 6/9/2017 for the cooking facilities open to the corridor on 2 North and 3 North and installed them on 6/16/17.  2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.  After checking 100% of the cooking facilities open to the corridor, we found 1 north not provided with a fire extinguisher that opens to the corridor using cooking facilities. Fire extinguishers were installed at each of the 3 cooking facilities open to the corridor on 6/16/2017.  3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.  The Facilities Director will educate all maintenance staff regarding regulations for kitchen fire extinguisher placement and how to inspect them by June 30, 2017		

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K 324	Continued From page 4 deficiency affected 3 of 21 smoke compartments.  NFPA 101, 19.7.6 NFPA 19.3.2.5.3(8)  Observation and interview with the maintenance director on 6/5/17 between 9:51 PM and 10:30 PM revealed the cooking facilities open to the corridor on 2 North and 3 North were not provided with fire extinguishers.  The maintenance director was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 6/6/17.	K 324	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.  All cooking facilities open to the corridor will be checked monthly on an ongoing basis as part of our routine inspection schedule, by the facility director or maintenance assistant. The results of the monthly checks will be reported to QAPI committee x 3 months.		
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by:	K 353	K 353 Sprinkler System Maintenance and Testing  1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  It is the facilities practice to provide maintenance, testing and maintenance of the automatic sprinkler and standpipe system that effect all 21 smoke compartments. The facility scheduled a 5 year sprinkler gauge calibration/replacement effecting all 21 smoke compartments by a certified state licensed inspector on 6/7/2017. The calibration/replacement was conducted on 6/13/2017.	7/22/17 CPN	

The facility scheduled relocation of the sprinkler head that was within 4 inches of the wall in room 126 on 6/7/2017. The relocation is to be completed by a certified state licensed installer by 6/30/2017.

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K 353	Continued From page 5 Based on observation, record review and interview, the facility failed to maintain the automatic sprinkler system. This deficiency affected all 21 smoke compartments.  NFPA 101, 19.3.5 NFPA 13, 8.6.3.3  The findings include:  Observation, record review and interview with the maintenance director on 6/5/17 at 9:05 PM revealed; 1. The 5 year sprinkler gauge calibration/replacement had not been conducted. 2. Room 126 has a sprinkler within 4 inches of the wall. The maintenance director was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 6/6/17.	K 353	2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.  100% of all sprinkler heads have been inspected by the Facilities Director and no additional deficient sprinklers were found.		
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on	<del>K 363</del>	3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.  The Facilities Director will educate all maintenance staff regarding smoke compartments, sprinkler calibration/replacement and how to inspect them by June 30, 2017  4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.  Maintenance, Testing and maintain of the automatic sprinkler and standpipe system that effects all 21 smoke compartments for 5 year sprinkler gauge calibration/replacement will be conducted every 5 years on an ongoing basis as part of the routine inspection schedule, by the facility director or maintenance assistant. The results of the next check will be reported to the QAPI committee at the next meeting following the inspection.		

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K 363	Continued From page 6 corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor doors. This deficiency affected 2 of 21 smoke compartments.  NFPA 101, 19.6.3.5  The findings include:  Observation and interview with the maintenance director on 6/5/17 between 7:35 PM and 10:00 PM revealed resident room doors 123 and 238 failed to close to a positive latch.  The maintenance director was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 6/6/17.	K 363	K 363 Corridor- Doors  1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  It is the facilities practice to ensure that we maintain Corridor Doors insuring positive latching for 2 of the 21 smoke compartments. The facility inspected the doors on 6/6/2017 at resident room 123 and 238 that failed to close and positive latch. Work to create positive latching at resident room door 123 and 238 that effects 2 of the 21 smoke compartments will be completed by 6/30/2017.  2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.  100% compliance was noted for the other 19 smoke compartments.  3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.  The Facilities Director will educate all maintenance staff regarding positive latching of all doors and how to inspect them by June 30, 2017		7/22/17 CPN
K 918	NFPA 101 Electrical Systems - Essential Electric	K 918			

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NAME OF PROVIDER OR SUPPLIER

**ASBURY PLACE AT MARYVILLE**

STREET ADDRESS, CITY, STATE, ZIP CODE

**2648 SEVIERVILLE RD  
MARYVILLE, TN 37804**

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K 918 Continued From page 7

SS=D Syste

**Electrical Systems - Essential Electric System  
Maintenance and Testing**

The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.

Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

This STANDARD is not met as evidenced by:  
Based on observation and interview, the facility failed to maintain generators. This deficiency affected 1 Of 21 smoke compartments.

363  
K-918

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.

Positive door latching in all 21 smoke compartments will be checked monthly on an ongoing basis as part of our routine inspection schedule, by the facility director or maintenance assistant. The results of the monthly checks will be reported to the QAPI committee x 3 months.

**K 918 Electrical Systems- Essential  
Electrical Systems**

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  
It is the facilities practice to ensure that we maintain Electrical Systems that affects 1 of 21 smoke compartments. The facility inspected the generator room on the south wing on 6/6/2017. All storage items placed in the generator room during that time was removed on 6/7/2017.
2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.  
100% compliance was noted for other Electrical Systems that affect the 21 smoke compartments.

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K 918	Continued From page 8  NFPA 101, 19.7.6 NFPA 110, 7.11.1  The finding includes:  Observation and interview with the maintenance director on 6/5/17 at 10:18 PM revealed the generator room on the South wing was being used for storage.  The maintenance director was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 6/6/17.	K 918	3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.  The Facilities Director will educate all maintenance staff regarding no storage of any items in the generator rooms by June 30, 2017		
K 923	NFPA 101 Gas Equipment - Cylinder and Container Storage  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.  The facility will inspect the generator room ensuring to maintain area without storage during our weekly routine inspection schedule, by the facility director or maintenance assistant.  This will be done on an ongoing basis and reported to the QAPI committee x 3 months.  K 923 Gas Equipment- Cylinder and Container Storage		
			1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  It is the facilities practice to ensure that we maintain Gas Equipment- Cylinder and Container Storage and proper signage that effect 2 of 21 smoke compartments .The facility inspected and ordered the required signage for the Oxygen storage on 1 North and 2 North on 6/16/2017. Signage will be installed at the 1 North and 2 North storage area by 6/30/2017.		7/22/17 CPN

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/06/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASBURY PLACE AT MARYVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2648 SEVIERVILLE RD MARYVILLE, TN 37804</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 923	<p>Continued From page 9</p> <p>stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain oxygen storage areas. This deficiency affected 2 of 21 smoke compartments. NFPA 101, 19.7.6 NFPA 99, 11.3.4.2</p> <p>The findings include:</p> <p>Observation and interview with the maintenance director on 6/5/17 between 8:22 PM and 9:45 PM revealed;</p> <ol style="list-style-type: none"> <li>1. The main oxygen storage room and the oxygen storage on 2N did not have the required signage.</li> <li>2. The main oxygen storage room had combustibles stored within 5 feet of cylinders.</li> </ol> <p>The maintenance director was present when the deficiencies were identified and acknowledged by the administrator during the exit conference on 6/6/17.</p>	K 923	<p>The facility inspected and determined to relocate the Main storage area from 1 North to the 1 North dock area to maintain a noncombustible storage area for cylinders. A quote was acquired on 6/12/2017 by fencing company to relocate and install fencing on 6/16/2017. Permanent storage for the main storage area will be completed on 6/30/2017.</p> <ol style="list-style-type: none"> <li>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</li> </ol> <p>100% compliance was noted for other storage areas with in the 21 smoke compartments.</p> <ol style="list-style-type: none"> <li>3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.</li> </ol> <p>The Facilities Director will educate all central supply, nursing, housekeeping, and maintenance staff regarding proper oxygen storage and signage of by June 30, 2017</p>		

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## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN0505	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  06/06/2017
NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT MARYVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
N 002	<del>1200-8-6 No Deficiencies</del>  During the life safety portion of the survey conducted on 6/5 & 6/6/17, no deficiencies were cited under 1200-8-6 standards for nursing homes.	N 002	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.  The facility will inspect the Gas Equipment -Cylinder and Storage areas ensuring to maintain area without combustible material and proper signage during our weekly routine inspection schedule, by the facility director or maintenance assistant. These checks will be done on an ongoing basis and will be reported to the QAPI committee x 3 months.

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

8899

14YY21

LNHA

6/21/17

If continuation sheet 1 of 1

6/22/17